

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>203 Academy Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Alonzo</u> Middle <u>Abbott</u> Last		4. DATE OF DEATH Month <u>12</u> /17 Year <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1881</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Langrall's Island, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel H. Abbott</u>		14. MOTHER'S MAIDEN NAME <u>Celestine Langrall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs. George Abbott</u>		Address <u>Cambridge, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/7</u> , 19 <u>47</u> , to <u>12/17</u> , 19 <u>55</u> that I last saw the deceased alive on <u>12/16</u> , 19 <u>55</u> , and that death occurred at <u>3:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter E. Gunby Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>405 Church St.</u>	
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR.</u>		DATE SIGNED <u>Cambridge Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/19/55</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Dorchester MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Granville LeCompte</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>John H. S.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		65		M		W		1880		BALTIMORE		MD		USA				MAY 28 1956		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
LABORER		8		M		C		HEART DISEASE		NATURAL		3 WEEKS		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF ARCHIVIST		SIGNATURE OF CHIEF OF BUREAU		SIGNATURE OF ASSISTANT CHIEF OF BUREAU		SIGNATURE OF DEPUTY CHIEF OF BUREAU		SIGNATURE OF SECRETARY		SIGNATURE OF CLERK		SIGNATURE OF ARCHIVIST	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11894

11914 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Taylors Island P.O.</u>		<u>Lifetime</u>		TOWN <u>Taylors Island P.O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>At Home below Madison</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)				12 29 1955			
<u>GEORGIA WALLACE ABBOTT</u>							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>2-16-1892</u>	<u>63</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Schoolteacher</u>		<u>Public Schools</u>		<u>Taylors Island</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph E. Wallace</u>				<u>Georgia Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mr. James L. Abbott Taylors Island, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>GALL BLADDER DISEASE</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>25 SEPT., 1955</u> to <u>29 DEC., 1955</u> , that I last saw the deceased alive on <u>28 DEC., 1955</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter E. Hunt</u> M.D.				ADDRESS (Street, city, town, state) <u>Cambridge, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-30-55</u>		<u>Brick Church Cemetery</u>		<u>Taylors Island Maryland</u>	
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>John Hall, R.O.</u>		<u>LeCompte Funeral Service</u>		<u>Cambridge, Md.</u>	
DATE <u>Dec. 30 1955</u>							

11801

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1912

Form 100-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF UNION

23. SIGNATURE OF COUNTY

24. SIGNATURE OF CITY

25. SIGNATURE OF TOWN

26. SIGNATURE OF VILLAGE

27. SIGNATURE OF PARISH

28. SIGNATURE OF CHURCH

29. SIGNATURE OF SYNAGOGUE

30. SIGNATURE OF MOSQUE

31. SIGNATURE OF TEMPLE

32. SIGNATURE OF MONASTERY

33. SIGNATURE OF CONVENT

34. SIGNATURE OF NUNNERY

35. SIGNATURE OF PRIORY

36. SIGNATURE OF ABBEY

37. SIGNATURE OF BISHOPRIC

38. SIGNATURE OF ARCHBISHOPRIC

39. SIGNATURE OF DIOCESE

40. SIGNATURE OF PARISH

41. SIGNATURE OF CHURCH

42. SIGNATURE OF SYNAGOGUE

43. SIGNATURE OF MOSQUE

44. SIGNATURE OF TEMPLE

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 1. NAME OF DECEASED
 2. SEX
 3. AGE
 4. DATE OF BIRTH
 5. PLACE OF BIRTH
 6. OCCUPATION
 7. CAUSE OF DEATH
 8. PLACE OF DEATH
 9. TIME OF DEATH
 10. SIGNATURE OF PHYSICIAN
 11. SIGNATURE OF REGISTRAR
 12. SIGNATURE OF WITNESSES
 13. SIGNATURE OF DECEASED
 14. SIGNATURE OF NEXT OF KIN
 15. SIGNATURE OF CLERGYMAN
 16. SIGNATURE OF JUDGE
 17. SIGNATURE OF SHERIFF
 18. SIGNATURE OF CORONER
 19. SIGNATURE OF JURY
 20. SIGNATURE OF COURT
 21. SIGNATURE OF STATE
 22. SIGNATURE OF UNION
 23. SIGNATURE OF COUNTY
 24. SIGNATURE OF CITY
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 36. SIGNATURE OF ABBEY
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 38. SIGNATURE OF ARCHBISHOPRIC
 39. SIGNATURE OF DIOCESE
 40. SIGNATURE OF PARISH
 41. SIGNATURE OF CHURCH
 42. SIGNATURE OF SYNAGOGUE
 43. SIGNATURE OF MOSQUE
 44. SIGNATURE OF TEMPLE

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		c. LENGTH OF STAY IN 1b <u>None</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock (Rural)</u>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		d. STREET ADDRESS <u>Cambridge, Maryland</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Boy</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>Dec. 16 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15th. Dec. 1955</u>
9. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR Months — Days —	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tommie Luke</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Louise Beasley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, diffuse, subarachnoidal</u> 771.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Under Prematurity, & Immaturity (30wks.)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydronephrosis, bilateral, Atelectasis, extensive of lungs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>21 hrs.</u> "
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — — — — —	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — —	20f. (City or town) (County) (State) — — — — —
21. I certify that I attended the deceased from <u>Dec. 15</u> , 19 <u>55</u> , to <u>Dec. 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 16</u> , 19 <u>55</u> , and that death occurred at <u>9:12 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12-16-56</u>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>		<u>Cambridge, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-16-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hurlock, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Inoue</u>		ADDRESS <u>Hurlock, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>March 20 56</u>
		24b. REGISTRAR'S SIGNATURE <u>John Inoue, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF DEATH	
JAN 10 1901		JAN 10 1901	
AGE		AGE	
10		10	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
OCCUPATION		OCCUPATION	
STUDENT		STUDENT	
EDUCATION		EDUCATION	
SCHOOL		SCHOOL	
TEACHER		TEACHER	
PARENTS		PARENTS	
FATHER		FATHER	
MOTHER		MOTHER	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF INTERMENT		DATE OF INTERMENT	
JAN 10 1901		JAN 10 1901	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
OFFICIAL SEAL		OFFICIAL SEAL	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF FILING		DATE OF FILING	
JAN 10 1901		JAN 10 1901	

BUREAU V. S.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11915 CERTIFICATE OF DEATH

11895

Reg. Dist. No. 116

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Dorchester</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Vienna</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Vienna</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00			STREET ADDRESS (If rural give location) /		
3. NAME OF DECEASED: (First) (Middle) (Last) Don P. Bowens			4. DATE (Month) (Day) (Year) OF DEATH: 12 17 19 55		
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 8-6-1881		9. AGE last birthday: 74 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Charles Bowens</u>			14. MOTHER'S MAIDEN NAME: <u>Nancy Stewart</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>162-18-1248</u>		17. INFORMANT & ADDRESS: <u>Mrs. Lillie Bowens, Vienna, Md.</u>
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> DUE TO					
ANTECEDENT CAUSE (B) <u>Hypertensive Cardiovascular Disease</u> DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>17-6-</u> , 19 <u>54</u> to <u>12-17-55</u> , that I last saw the deceased alive on <u>12-17-</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. SIGNATURE <u>J. Edwin Fassett</u> ADDRESS <u>227 Pine St-Camb., Md.</u> DATE SIGNED <u>12-20-55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rhodesdale Cemetery</u> LOCATION (City, town, or county) (State) <u>Rhodesdale, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 21 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>H.M. StClair, Jr., -High St-Camb., Md.</u>	

CONSTITUTION OF THE STATE OF MARYLAND

BUREAU V. S.

DEC 27 1965

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CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> <u>13</u>			
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>00</u> <u>237 Cedar St</u>				STREET ADDRESS (If rural give location) <u>237 Cedar St</u> <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John</u> <u>Garfield</u> <u>Chester</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>7</u> <u>19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>1-6-1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Webster Chester</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Bishop</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>			16. SOCIAL SECURITY NO. <u>216-03-1676</u>	17. INFORMANT & ADDRESS: <u>Clara Jones-Cedar St-Camb., Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>							
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 28, 1953</u> to <u>Dec. 7, 1955</u> , that I last saw the deceased alive on <u>Dec. 7, 1955</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Edwin Fassett,</u>		M.D. <u>227 Pine St-Camb., Md.</u>		DATE SIGNED <u>12-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Meekins Neck Cemetery</u>		LOCATION (City, town, or county) (State) <u>Meekins Neck, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 11, 1955</u>		REGISTRAR'S SIGNATURE <u>John H. St. Clair, Jr.</u>		24. FUNERAL DIRECTOR <u>H.M. StClair, Jr.</u>		ADDRESS <u>-High St-Camb., Md</u>	

MARGIN RESERVED FOR BINDER

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 13 1955

BUREAU V. S.

11916

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Northampton</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rhodesdale - Rural</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cheriton</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Eldorado</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Geneva</u> <u>Emory</u> <u>Cochran</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 28</u> <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>October 30, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Vienna, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas C. Sellers</u>				14. MOTHER'S MAIDEN NAME: <u>Gertrude Solloway</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Mrs. Carl B. Payne, Rhodesdale, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						<u>1 yr +</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Essential Hypertension</u>						<u>1 yr +</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/26</u> , 19 <u>53</u> , to <u>12/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/28</u> , 19 <u>55</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W.C. Harrison MD</u>		M. D.		ADDRESS <u>Hurlock Md.</u>		DATE SIGNED <u>12/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 29-1955</u>		REGISTRAR'S SIGNATURE <u>Cheriton</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

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RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11898

11917

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Blackwater Refuge</u>		<u>1 year</u>		TOWN <u>Fishing Creek</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Home of Key Wallace</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALICE ADAMS CREIGHTON</u>				<u>Dec. 26 1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>F</u>		<u>W</u>		<u>W</u>		<u>11-30-1878</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>77 yrs.</u>		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>				<u>Domestic</u>		<u>Barren Island, Md.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alonza Adams</u>				<u>Mary Angeline Aaron</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>None</u>		<u>Mrs. Cornelius Wallace Church Creek, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Bilateral cerebral embolism & paralysis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Antero-schistic CVD & chronic fibrillation</u>						<u>48 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Antero-schistic generalised</u>						<u>2 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 26</u>, 19<u>55</u>, to <u>Dec 26</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec 26</u>, 19<u>55</u>, and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James L. Thompson</u> M.D.				ADDRESS (Street, city, town, state) <u>Cambridge Md</u>		DATE SIGNED <u>Dec 27, 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-28-55</u>		<u>Hoosier Memorial</u>		<u>Fishing Creek, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec 27 1955</u>		<u>John D. Lee, Jr.</u>		<u>LeCompte Funeral Service</u>		<u>Cambridge, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1917

1. NAME OF DECEASED

MARYLAND

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF MINISTER OF THE GOSPEL

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF CLERK

18. SIGNATURE OF JURY

19. SIGNATURE OF DECEASED

20. SIGNATURE OF WITNESSES

21. SIGNATURE OF REGISTRAR

22. SIGNATURE OF CLERK

23. SIGNATURE OF JURY

24. SIGNATURE OF DECEASED

25. SIGNATURE OF WITNESSES

26. SIGNATURE OF REGISTRAR

27. SIGNATURE OF CLERK

28. SIGNATURE OF JURY

29. SIGNATURE OF DECEASED

BUREAU V. 8

DEC 28 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

111918
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester Co.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>20 yrs. 9 mths.</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cambridge, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural, give location) <u>---</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Elizabeth DeGruchy</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 30 19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>9-25-88</u>		9. AGE last birthday: <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Godfrey Keeper</u>				14. MOTHER'S MAIDEN NAME: <u>Marie Swartz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No.: <u>---</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u>		DUE TO				<u>about 3 minutes</u>	
Antecedent cause(s) (b) <u>arterio Sclerotic Cardio-Vascular</u>		DUE TO				<u>10-15 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating <u>underlying cause last</u> (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Not while work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Eldridge H. Webb</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>30 Dec 1955</u>	
		M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		LOCATION (City, town, or county) (State) <u>Camb. Dor Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 2, 1956</u>		REGISTRAR'S SIGNATURE <u>John H. Webb</u>		24. FUNERAL DIRECTOR <u>John H. Webb</u>		ADDRESS <u>Cambridge, Md.</u>	

BUREAU V. S.

JAN 6 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11900

11900

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
21 <u>Cambridge</u>		<u>6 years</u>		<u>Cambridge RFD # 1</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
67 <u>Cambridge Md. Hospital-11/9/55</u>				<u>with John Orr</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>EDITH</u> (Middle) <u>BARKER</u> (Last) <u>ELLIS</u>				<u>Dec.</u> <u>3</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>S</u>	<u>Jan. 24, 1877</u>	<u>78 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Accountant</u>		<u>Accounting</u>		<u>Flushing L.I., N.Y.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John P. Ellis</u>				<u>Mary Augusta Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>069-01-6502 A</u>		<u>Mrs. John Orr Cambridge RFD #1, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
587.0 IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Nephritis + Nephrosis</u>						<u>1 Week</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>acute Pancreatitis</u>						<u>2 wks</u>	
(C) <u>Parotitis, Rt</u>						<u>3 wks</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>10 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>		<u></u>		<u></u>		<u></u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u></u>		<u></u>		<u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?			
<u></u>		<u></u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>11-8</u> , 19 <u>55</u> , to <u>12-3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-3-55</u> , 19 <u>55</u> , and that death occurred at <u>11:57</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edredge H. Wolff</u> M.D.				ADDRESS (Street, city, town, state) <u>Cambridge, Md</u>		DATE SIGNED <u>12-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/7/55</u>		<u>Flushing Cemetery</u>		<u>Flushing Long Island, N.Y.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 7, 1955</u>		<u>John H. Orr, Jr.</u>		<u>LeCompte Funeral Service</u>		<u>Cambridge, Md.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11901

11919 CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL or end, give nearest town) Rhodesdale		LENGTH OF STAY (in this place) 3 Years		CITY (If outside corporate limits, write RURAL and give nearest town) Rhodesdale			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 1				STREET ADDRESS (If rural give location) R.D. # 1			
3. NAME OF DECEASED (Type or Print) Mary Anne Freeny				4. DATE OF DEATH (Month) Dec. (Day) 9. (Year) 1955.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH May 26, 1872.	9. AGE last birthday 83. yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Worcester County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fooks				14. MOTHER'S MAIDEN NAME Elizabeth Dryden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS (Name) Mrs. Levin T. Watkins, R.D. # 1.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION Rhodesdale, Maryland.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks -	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1955, to Dec 9, 1955, that I last saw the deceased alive on Dec 9, 1955, and that death occurred at 12 Noon, from the causes and on the date stated above.							
SIGNATURE J. S. Kuhlman				ADDRESS (Street, city, town, state) M.D. Sharptown, Maryland.		DATE SIGNED 12/10/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 12-1955.		NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park.		LOCATION (City, town, or county) (State) Salisbury, Maryland.	
24. REC'D BY REGISTRAR DEC 14 1955		REGISTRAR'S SIGNATURE Charles Hastings		25. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.			

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

11301

BUREAU V. S.

DEC 14 1935

RECEIVED

11902

MARYLAND 11901

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> LENGTH OF STAY <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shirlock, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Katherine Elizabeth</u> (First) <u>Hurst</u> (Middle) <u>Hurst</u> (Last)		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/27/1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>89</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Beckwith</u>		14. MOTHER'S MAIDEN NAME <u>Emma Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Miss Ruby Hurst, Shirlock</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
334X Immediate cause (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>			6 MOS.
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>KIDNEY INFECTION</u>			3 WKS.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/3, 1955, to 12/13, 1955, that I last saw the deceased alive on 12/10, 1955, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE Halter E. Hurst, M.D. (Degree or title) ADDRESS Cambridge, MD DATE SIGNED 15 Dec 55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>12/16/55</u>	NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>Dec 15 1955</u>	REGISTRAR'S SIGNATURE <u>John I. Hall, D.O.</u>	24. FUNERAL DIRECTOR <u>Frank S. Milloughby</u>	ADDRESS <u>East New Market, Md</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 10 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11902
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11903

Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dor.		MARYLAND		STATE Md.		COUNTY Dor.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
13 TOWN Cambridge				TOWN Cambridge 13			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 000 209 Pine St.				STREET ADDRESS (If rural, give location) 209 Pine St. 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
George W. Kane				Dec. 9, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	July 15, 1901	54 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Unemployed						Maryland USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John Airon Kane				Margaret Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no						Sarah Nichols	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
916.0 Immediate cause (a) Third & fourth Degree Burns entire body.						Instant	
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> (State)	
				Cambridge, Dor. 09 Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 9 '55 11 PM.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Trapped in burning building.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		John Mace		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> Dec. 12 '55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 12 '55		Bethel Cemetery		Cambridge, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Dec. 12, 1955		John Mace Jr.		Herbert M. St. Clair		Cambridge, Md.	

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DEC 13 1955

BUREAU V. S.

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11903

CERTIFICATE OF DEATH

11904

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>14 days</u>		CITY OR TOWN <u>Hurlock - Rural</u>		CITY OR TOWN <u>Hurlock - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location) <u>Near Williamsburg</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>John</u>		(Middle) <u>Wesley</u>		(Last) <u>Lake</u>		(Month) <u>December</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>About 1884</u>	9. AGE last birthday <u>About 71 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Lake</u>				14. MOTHER'S MAIDEN NAME <u>Mary (maiden name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mrs. Minnie S. Lake, Hurlock, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
560.0 IMMEDIATE CAUSE (A) <u>Pulmonary Embolus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Postoperative condition</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Secondary</u>							
19a. DATE OF OPERATION <u>12/2/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large inguinal hernia and hydrocele</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>11:16</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/2/55</u> , to <u>12/2/55</u> , that I last saw the deceased alive on <u>12/2/55</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>Cambridge, Maryland</u>				DATE SIGNED <u>Dec. 10, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) <u>Near Hurlock, Maryland</u> (State)	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalburg, Md.</u> ADDRESS			
DATE <u>Dec. 11, 1955</u>							

11920

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Hurlock</u>		LENGTH OF STAY (in this place) <u>3 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hurlock</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>07</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Margaret Elizabeth Marine</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 25 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>October 11, 1862</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Harper</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Lankford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Harry Arnett, Hurlock, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Colon</u>						<u>1 year</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> , to <u>12/15/</u> , 19 <u>55</u> that I last saw the deceased alive on <u>12/24/</u> , 19 <u>55</u> , and that death occurred at <u>1:40P</u> M, from the causes and on the date stated above. SIGNATURE <u>W. C. Harrison</u> M. D. <u>Hurlock, Maryland</u> DATE SIGNED <u>Dec. 28, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hurlock, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 29-1955</u>		REGISTRAR'S SIGNATURE <u>Chas W. Hastings</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V.S.

JAN 5 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11906

11921
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Rural Cambridge</u>		<u>Lifetime</u>		TOWN <u>Rural Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At Home</u>				STREET ADDRESS (If rural, give location) <u>Hills Point</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>J.</u>		(Middle) <u>MILTON</u>		(Last) <u>MARSHALL</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>9/10/1878</u>	
				9. AGE last birthday: <u>77</u> yrs.		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>6</u> (Year) <u>1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Seafood</u>		11. BIRTHPLACE (State or foreign country): <u>Hills Point, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James A. Marshall</u>				14. MOTHER'S MAIDEN NAME: <u>Louisa Seward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Edna Marshall, R.F.D. Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a)..... <u>Coronary occlusion</u> DUE TO						<u>30 Min.</u>	
Antecedent cause(s) Diseases or conditions, if any, (b)..... giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE		<u>James Marshall</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>12/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Speddens-Sewards Cemetery</u>		LOCATION (City, town, or county) <u>James Dorchester Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>Dec. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Md.</u>	

BUREAU V. S.

DEC 15 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11907

CERTIFICATE OF DEATH

Reg. Dist. No. 116

Items 7, 9, Film 190 12-28-55 et

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge House</u>		STREET ADDRESS (If rural, give location) <u>Pirkins alley</u>	
3. NAME OF DECEASED (Type or Print) <u>EARNEST</u> (First) <u>Edward</u> (Middle) <u>Mc HONEY</u> (Last)		4. DATE OF DEATH <u>12-18-1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Approx. 12-1-1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT <u>(Mrs.) Victoria Pinder</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Lobar pneumonia</u>			<u>1 day</u>
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>			<u>?</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/12</u> , 19 <u>55</u> , to <u>12/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>55</u> , and that death occurred at <u>7:30</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Laurence Manyanov M.D.</u>		DATE SIGNED <u>12/21/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12-21-55</u>	NAME OF CEMETERY OR CREMATORY <u>Cambridge</u>
LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>			
DATE REC'D BY LOCAL REG. <u>Dec 21, 1955</u>	REGISTRAR'S SIGNATURE <u>John D. Henry</u>	24. FUNERAL DIRECTOR <u>Leon W. Henry</u>	ADDRESS <u>Cambridge</u>

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DEC 23 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11906

CERTIFICATE OF DEATH

11909

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		LENGTH OF STAY (in this place) <u>25 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At Home 132 Race Street</u>				STREET ADDRESS (If rural give location) <u>132 Race Street</u>			
3. NAME OF DECEASED (Type or Print) <u>DAISY WILLIAMS MEIZER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 15 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>8/3/1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Seipp</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Bollinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. George O. Meizer Cambridge, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
350x IMMEDIATE CAUSE (A) <u>Cardiovascular renal decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Parkinson's Disease</u>				<u>10 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/12</u>, 19<u>55</u>, to <u>12/15</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/12</u>, 19<u>55</u>, and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Lawrence Maryanov</u>				ADDRESS (Street, city, town, state) <u>M.D. 136 Race St. Cambridge, Md.</u>		DATE SIGNED <u>12/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		LOCATION (City, town, or county) (State) <u>East New Market, Maryland</u>	
24. REC'D BY REGISTRAR <u>John H. Lee, R.D.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service Cambridge, Md.</u>		ADDRESS	
DATE <u>Dec. 18, 1955</u>							

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF CHURCH

17. SIGNATURE OF OTHER

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11908

11905 CERTIFICATE OF DEATH

Reg. Dist. No. 1116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		3 days		13 TOWN <u>Cambridge</u>			
67 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md. Hospital</u>				STREET ADDRESS (If rural give location) <u>Belevedere Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>STELLA</u> (Middle) <u>TINSLEY</u> (Last) <u>MEEKINS</u>				(Month) <u>Dec.</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>12/27/1884</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Dallas, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Tinsley</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Tofern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Beverly Stevens Cambridge, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
330x IMMEDIATE CAUSE (A) <u>Subarachnoid Hemorrhage - Int. Capable</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary stenosis</u>				<u>yes</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Atherosclerosis</u>				<u>yes</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia Bilateral</u>				<u>3 days</u>			
19a. DATE OF OPERATION <u>12-11</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>12-11</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-8</u> , 19 <u>55</u> , to <u>12-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-11</u> , 19 <u>55</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				DATE SIGNED <u>12-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <u>LeCompte Funeral Service Cambridge, Md.</u>	
DATE <u>Dec 13, 1955</u>							

1955 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

REG. GEN. 116

1. PLACE OF DEATH

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
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COUNTY
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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11910

11922 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Church Creek</u>		<u>7 years</u>		OR TOWN <u>East Church Creek, R.F.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u>		(Middle) <u>Brinsfield</u>		(Last) <u>Mitchell</u>		(Month) (Day) (Year) <u>Dec. 2, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 25, 1875</u>	<u>80</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George D. Brinsfield</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. J. Lawton Jones, Church Creek, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>334X</u> IMMEDIATE CAUSE (A) <u>CEREBRAL ARTERIO SCLEROSIS</u>						<u>7 YEARS</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 23 NOV 55</u> <u>49</u> <u>2 DEC.</u> <u>1955</u> <u>5:45 A.</u> to <u>1955</u> that I last saw the deceased <u>alive on</u> <u>23 NOV 55</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. E. Gurnby, Jr.</u>				ADDRESS (Street, city, town, state) <u>Cambridge MD.</u>			
DATE SIGNED <u>2 DEC 55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John D. R. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Howard</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE <u>Dec. 4, 1955</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. DECEASED'S NAME (Last, first, middle)

2. DECEASED'S SEX (Male or Female)

3. DECEASED'S AGE (Years, months, days)

4. DECEASED'S BIRTH DATE (Month, day, year)

5. DECEASED'S BIRTH PLACE (City, State, Country)

6. DECEASED'S RACE (White, Negro, Other)

7. DECEASED'S OCCUPATION (If any)

8. DECEASED'S MARITAL STATUS (Single, Married, Widowed, Divorced)

9. DECEASED'S DATE OF DEATH (Month, day, year)

10. DECEASED'S TIME OF DEATH (Hour, minute)

11. DECEASED'S PLACE OF DEATH (City, State, Country)

12. DECEASED'S CAUSE OF DEATH (If known)

13. DECEASED'S MANNER OF DEATH (Natural, Accidental, Suicide, Homicide)

14. DECEASED'S SIGNATURE (If known)

15. DECEASED'S ADDRESS (If known)

16. DECEASED'S RELATIONSHIP TO DECEASED (If known)

17. DECEASED'S DATE OF BIRTH (Month, day, year)

18. DECEASED'S TIME OF BIRTH (Hour, minute)

19. DECEASED'S PLACE OF BIRTH (City, State, Country)

20. DECEASED'S CAUSE OF BIRTH (If known)

21. DECEASED'S MANNER OF BIRTH (Natural, Accidental, Suicide, Homicide)

22. DECEASED'S SIGNATURE (If known)

23. DECEASED'S ADDRESS (If known)

24. DECEASED'S RELATIONSHIP TO DECEASED (If known)

25. DECEASED'S DATE OF DEATH (Month, day, year)

26. DECEASED'S TIME OF DEATH (Hour, minute)

27. DECEASED'S PLACE OF DEATH (City, State, Country)

28. DECEASED'S CAUSE OF DEATH (If known)

29. DECEASED'S MANNER OF DEATH (Natural, Accidental, Suicide, Homicide)

30. DECEASED'S SIGNATURE (If known)

31. DECEASED'S ADDRESS (If known)

32. DECEASED'S RELATIONSHIP TO DECEASED (If known)

33. DECEASED'S DATE OF BIRTH (Month, day, year)

34. DECEASED'S TIME OF BIRTH (Hour, minute)

35. DECEASED'S PLACE OF BIRTH (City, State, Country)

36. DECEASED'S CAUSE OF BIRTH (If known)

37. DECEASED'S MANNER OF BIRTH (Natural, Accidental, Suicide, Homicide)

38. DECEASED'S SIGNATURE (If known)

39. DECEASED'S ADDRESS (If known)

40. DECEASED'S RELATIONSHIP TO DECEASED (If known)

41. DECEASED'S DATE OF DEATH (Month, day, year)

42. DECEASED'S TIME OF DEATH (Hour, minute)

43. DECEASED'S PLACE OF DEATH (City, State, Country)

44. DECEASED'S CAUSE OF DEATH (If known)

45. DECEASED'S MANNER OF DEATH (Natural, Accidental, Suicide, Homicide)

46. DECEASED'S SIGNATURE (If known)

47. DECEASED'S ADDRESS (If known)

48. DECEASED'S RELATIONSHIP TO DECEASED (If known)

BUREAU V. S.

DEC 7 1955

RECEIVED

James A. Jones

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11911

11907

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>RURAL Cambridge</u>		2 Weeks		TOWN <u>Rural Cambridge</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
67 <u>Cambridge Maryland Hospital</u>				/			
3. NAME OF DECEASED (Type or Print)			(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)	
<u>Mary Spedden North</u>						<u>12 5 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.	
F	W	M	4/10/1881		74 yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Rural Cambridge, Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Spedden</u>				<u>Fannie Frazier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
No			None		<u>Mr. T. James North Rural Cambridge, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A)						<u>Coronary Occlusion</u>	
ANTECEDENT CAUSE(S) DUE TO						<u>Arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH	
						<u>2 wks</u>	
						<u>yes</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-9-</u> <u>1955</u> , to <u>12-5-</u> <u>1955</u> , that I last saw the deceased alive on <u>12-5-</u> <u>1955</u> , and that death occurred at <u>4:45</u> M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>T. B. ...</u> M.D. <u>Cambridge</u>				<u>12-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/8/55</u>		<u>Greenlawn Cemetary</u>		<u>Cambridge Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Dec 8, 1955</u>		<u>John I. ...</u>		<u>LeCompte Funeral Service</u>		<u>Cambridge, Md.</u>	

CERTIFICATE OF DEATH

1955

BUREAU V. 8

DEC 16 1955

RECEIVED

INSTRUCTIONS
This certificate is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. A copy of this certificate is to be sent to the local health officer of the county or city in which the deceased resided. The certificate is to be filled out in duplicate, and the original is to be filed in the office of the Registrar. The duplicate is to be sent to the local health officer. The certificate is to be filled out in duplicate, and the original is to be filed in the office of the Registrar. The duplicate is to be sent to the local health officer.

11908 **CERTIFICATE OF DEATH**Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>Few Hours</u>		TOWN <u>Lincoln Road</u>		TOWN <u>Lincoln Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>ALETHA JANE PHILLIPS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 27, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 6, 1910</u>	9. AGE last birthday <u>45</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William G. Lee</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gertrude Kiah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Romie Phillips, Linas Road, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1490x IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular decompensation</u>				<u>10 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/21, 1955</u>, to <u>12/26, 1955</u>, that I last saw the deceased alive on <u>12/27, 1955</u>, and that death occurred at <u>7:30 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Lawrence Mangano</u> M.D.				ADDRESS (Street, city, town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>1/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/1/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Road Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lincoln Road, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John H. Lee, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. St. Clair, Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE <u>Jan 1, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

11923

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11913

Reg. Dist. 116

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 336

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Vienna</u>		<u>20 yrs.</u>		TOWN <u>Vienna</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Harmon E. Prince</u>				<u>Dec. 26 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>4-20-1890</u>	<u>65</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Antiqui Dealer</u>			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>N.C.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Prince</u>				<u>Catherine Townsend</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>Yes</u>		<u>World 1</u>				<u>Mrs Lillian E. Prince, Vienna, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>1 hr.</u>	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditons, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John Mace, Jr.</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-28-54</u>		<u>The Union Cemetery</u>		<u>Georgetown, Delaware</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>December 28-1955</u>		<u>Harry E. Hudson, Sr.</u>		<u>W. L. Marvel</u>		<u>Delmar, Delaware</u>	
<u>John Mace, Jr.</u>							

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1956

BUREAU V. S.

11909

11914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dor.	MARYLAND	STATE Md.	COUNTY Dor.
CITY (If outside corporate limits, write RURAL OR and give nearest town) 13 TOWN Cambridge		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cambridge 13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 209 Pine St.		STREET ADDRESS (If rural, give location) 209 Pine St. 1	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Edward	(Middle)	(Last) Quails	(Month) 12 (Day) 9 (Year) 55
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Sept. 23, 1913 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Md.
13. FATHER'S NAME: Elmer Quails		14. MOTHER'S MAIDEN NAME: Hattie Strawberry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: unk.	
17. INFORMANT & ADDRESS: Mrs. Hattie Quails			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
916.0 Immediate cause (a) Third & fourth degree burns entire body. DUE TO			Instant
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home	21c. (City or town) Cambridge Dor. 07 Md. (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 9 1955 M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Trapped in burning building.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE John Mace		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Dec. 12 '55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Dec. 12, 1955	NAME OF CEMETERY OR CREMATORY Washington Church Yard. (State) Hurlock, Md.	
DATE REC'D BY LOCAL REG. Dec 12, 1955	REGISTRAR'S SIGNATURE John Mace	24. FUNERAL DIRECTOR Leon W. Henry ADDRESS Cambridge, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 13 1955
BUREAU V. B.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11916

11910

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN <u>Cambridge</u>		TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<u>202 Gay Street</u>		<u>202 Gay Street</u>		<u>202 Gay Street</u>		<u>202 Gay Street</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Clarence Golt Raymond</u>				<u>Dec. 31, 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar. 22, 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days)		11. IF UNDER 24 HRS. (Hours) (Min.)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Public School Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Leipsic, Del</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Raymond</u>				14. MOTHER'S MAIDEN NAME <u>Laura Buckson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-10-8462</u>			
17. INFORMANT & ADDRESS <u>202 Gay Street, blanche P. Raymond, Cambridge, Md.</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/28/55</u> to <u>12/31, 1955</u> that I last saw the deceased alive on <u>12/29, 1955</u> and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Lawrence Mangano</u> M.D. <u>Cambridge, Md.</u> DATE SIGNED <u>1/3/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John D. [Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Thomas</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE <u>Jan 2, 1956</u>							

CERTIFICATE OF DEATH

1950

Reg. No. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERK

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF TOWNSHIP CLERK

24. SIGNATURE OF VILLAGE CLERK

25. SIGNATURE OF CITY CLERK

26. SIGNATURE OF STATE CLERK

27. SIGNATURE OF FEDERAL CLERK

28. SIGNATURE OF NATIONAL CLERK

29. SIGNATURE OF INTERNATIONAL CLERK

30. SIGNATURE OF UNITED NATIONS CLERK

31. SIGNATURE OF WORLD CLERK

32. SIGNATURE OF GLOBAL CLERK

33. SIGNATURE OF PLANETARY CLERK

34. SIGNATURE OF GALACTIC CLERK

35. SIGNATURE OF COSMIC CLERK

36. SIGNATURE OF UNIVERSE CLERK

37. SIGNATURE OF MULTIVERSE CLERK

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39. SIGNATURE OF OMNIVERSE CLERK

40. SIGNATURE OF EVERYTHING CLERK

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BUREAU V. S.

JAN 6 1956

RECEIVED

11924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Hurlock - Rural</u>		<u>Life</u>		TOWN <u>Hurlock - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bottom</u>				STREET ADDRESS (If rural, give location) <u>Bottom</u>			
3. NAME OF DECEASED: (First) <u>Linda</u>		(Middle) <u>Marlene</u>		(Last) <u>Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 23 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>October 6, 1955</u>		9. AGE last birthday: <u>—</u> yrs. <u>2</u> Months <u>17</u> Days <u>—</u> Hours <u>—</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Leslie Dobson</u>				14. MOTHER'S MAIDEN NAME: <u>Florence Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Florence Smith - Hurlock, Maryland, R.F.D.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Pneumonia</u>							
DUE TO							
Antecedent cause(s) (b) <u>—</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u>—</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John M. Smith</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/23/55</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Hurlock, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Dec 24-1955</u>		REGISTRAR'S SIGNATURE <u>Charles Hastings</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton & Son, Federalburg, Md.</u>		ADDRESS	

4005224395

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.

BUREAU V.

JAN 5 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11918

Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>17 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural, give location) <u>Pine Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Fred</u> <u>Strawberry</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 11 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>C olored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>About 1897</u>	9. AGE last birthday: <u>About 58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Canning Factory</u>		11. BIRTHPLACE (State or foreign country): <u>Hurlock, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Strawberry</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (ink.)) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Roland Strawberry, Hurlock, Maryland</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>9/6.0</u> Immediate cause (a)..... <u>Second and third degree burns entire body</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....						<u>23 hours</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Cambridge Dor. 09 Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec. 9, 1955 11</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Burned before getting out of burning</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> ; and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James Strawberry</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>Dec. 13 '55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Hurlock, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 13, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Frampton</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. J. Frampton and Son, Federalsburg, Md.</u>			

RECEIVED

DEC 15 1955

BUREAU V. 81

Item 7, Film G190 12-19-55 et

11912

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>13</u> <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>2 Hubert St</u>		STREET ADDRESS (If rural give location) <u>1</u> <u>2 Hubert St</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Zula</u> <u>Travers</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>4</u> <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-31-1888</u>
9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>- - - -</u>	11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u>
13. FATHER'S NAME: <u>Warner Redman</u>		14. MOTHER'S MAIDEN NAME: <u>Annie S. Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>- - - -</u>		16. SOCIAL SECURITY NO. <u>- - - -</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>			
ANTECEDENT CAUSE (S) <u>Hypertensive Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C) <u>- - - -</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov <u>3</u> , 19 <u>55</u> to Dec <u>4</u> , 19 <u>55</u> that I last saw the deceased alive on Dec <u>4</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. Edwin Fassett</u>		ADDRESS <u>227 Pine St-Camb., Md.</u>	
DATE SIGNED <u>Dec 8, 1955</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12-8-55</u>	NAME OF CEMETERY OR CREMATORY <u>Silent City Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cambridge-Dor-Md.</u>
DATE REC'D BY LOCAL REGISTRAR: <u>Dec 8, 1955</u>	REGISTRAR'S SIGNATURE <u>John H. StClair, Jr.</u>	24. FUNERAL DIRECTOR <u>H.M. StClair, Jr.</u>	ADDRESS <u>High St-Camb., Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 13 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11913

CERTIFICATE OF DEATH

11920

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		LENGTH OF STAY (In this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fishing Creek</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md. Hospital</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (Type or Print) <u>NELLIE FLOWERS WALLACE</u>				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>7/7/1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Barren Island, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Flowers</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Flowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-7442</u>		17. INFORMANT & ADDRESS <u>C. Wash Wallace Cambridge, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary artery thrombosis</u>				<u>7 mo.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>				<u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/11</u> , 19 <u>55</u> , to <u>12/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>55</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hoosier Mem. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hoopers Island, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>LeCompte Funeral Service Cambridge, Md.</u>			
DATE <u>Dec. 15, 1955</u>							

CERTIFICATE OF DEATH

1953

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. DATE OF DEATH (Month, Day, Year)

9. TIME OF DEATH (Hour, Minute)

10. CAUSE OF DEATH (Print or Write)

11. MEDICAL EXAMINATION (Print or Write)

12. SIGNATURE OF PHYSICIAN (Print or Write)

13. SIGNATURE OF REGISTRAR (Print or Write)

14. SIGNATURE OF WITNESS (Print or Write)

15. SIGNATURE OF DECEASED (Print or Write)

16. SIGNATURE OF NEXT OF KIN (Print or Write)

17. SIGNATURE OF CLERGYMAN (Print or Write)

18. SIGNATURE OF CHURCH OFFICER (Print or Write)

19. SIGNATURE OF BURIAL OFFICER (Print or Write)

20. SIGNATURE OF INTERMENT OFFICER (Print or Write)

21. SIGNATURE OF FUNERAL HOME (Print or Write)

22. SIGNATURE OF CEMETERY (Print or Write)

23. SIGNATURE OF BURIAL SOCIETY (Print or Write)

24. SIGNATURE OF OTHER (Print or Write)

25. SIGNATURE OF OTHER (Print or Write)

26. SIGNATURE OF OTHER (Print or Write)

27. SIGNATURE OF OTHER (Print or Write)

28. SIGNATURE OF OTHER (Print or Write)

29. SIGNATURE OF OTHER (Print or Write)

30. SIGNATURE OF OTHER (Print or Write)

31. SIGNATURE OF OTHER (Print or Write)

32. SIGNATURE OF OTHER (Print or Write)

33. SIGNATURE OF OTHER (Print or Write)

34. SIGNATURE OF OTHER (Print or Write)

35. SIGNATURE OF OTHER (Print or Write)

36. SIGNATURE OF OTHER (Print or Write)

37. SIGNATURE OF OTHER (Print or Write)

38. SIGNATURE OF OTHER (Print or Write)

39. SIGNATURE OF OTHER (Print or Write)

40. SIGNATURE OF OTHER (Print or Write)

41. SIGNATURE OF OTHER (Print or Write)

42. SIGNATURE OF OTHER (Print or Write)

43. SIGNATURE OF OTHER (Print or Write)

BUREAU V. S.

DEC 19 1953

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during the last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland. It is the duty of the physician or other qualified person to fill out this certificate truthfully and accurately. It is the duty of the registrar to check the certificate for completeness and accuracy, and to enter the information in the death register. It is the duty of the funeral home to check the certificate for completeness and accuracy, and to enter the information in the funeral home register. It is the duty of the cemetery to check the certificate for completeness and accuracy, and to enter the information in the cemetery register. It is the duty of the burial society to check the certificate for completeness and accuracy, and to enter the information in the burial society register. It is the duty of the interment officer to check the certificate for completeness and accuracy, and to enter the information in the interment officer register. It is the duty of the funeral home to check the certificate for completeness and accuracy, and to enter the information in the funeral home register. It is the duty of the cemetery to check the certificate for completeness and accuracy, and to enter the information in the cemetery register. It is the duty of the burial society to check the certificate for completeness and accuracy, and to enter the information in the burial society register. It is the duty of the interment officer to check the certificate for completeness and accuracy, and to enter the information in the interment officer register.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11925 **CERTIFICATE OF DEATH**

11921

Reg. Dist. No. 110

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Federalburg - Rural</u>		<u>5 years</u>		TOWN <u>Federalburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eldorado Road</u>				STREET ADDRESS (If rural give location) <u>Eldorado Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Wilbur Royce Wheatley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 20 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1892</u>		9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Civil Service-St. Elizabeth's Hospital</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward A. Wheatley</u>				14. MOTHER'S MAIDEN NAME <u>Annie V. Merrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-32-1001</u>		17. INFORMANT & ADDRESS <u>Lillian E. Wheatley, Federalburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Atheromatosis</u>						<u>1 yr 4</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 19, 1955</u> to <u>Dec. 20, 1955</u> that I last saw the deceased alive on <u>Dec. 19, 1955</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. C. Harrison</u>		M.D. <u>Hurlock, Maryland</u>		DATE SIGNED <u>December 20, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. REC'D BY REGISTRAR <u>Dec 22 1955</u>		REGISTRAR'S SIGNATURE <u>Charles W. Hastings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son, Federalburg, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

Form No. 10

1. DECEASED PERSON'S NAME (Print or Type)

2. PLACE OF BIRTH

3. SEX ☐ Male ☐ Female
 4. AGE ☐ Years ☐ Months ☐ Days
 5. DATE OF BIRTH ☐ Year ☐ Month ☐ Day

6. PLACE OF DEATH ☐ Home ☐ Hospital ☐ Other

7. CAUSE OF DEATH (Print or Type)

8. MANNER OF DEATH (Print or Type)

9. SIGNATURE OF PHYSICIAN (Print or Type)

10. SIGNATURE OF REGISTRAR (Print or Type)

11. SIGNATURE OF WITNESS (Print or Type)

12. SIGNATURE OF DECEASED PERSON (Print or Type)

13. SIGNATURE OF DECEASED PERSON'S NEXT OF KIN (Print or Type)

14. SIGNATURE OF DECEASED PERSON'S ATTORNEY (Print or Type)

15. SIGNATURE OF DECEASED PERSON'S MINISTER (Print or Type)

16. SIGNATURE OF DECEASED PERSON'S CHURCH (Print or Type)

17. SIGNATURE OF DECEASED PERSON'S FAMILY (Print or Type)

18. SIGNATURE OF DECEASED PERSON'S FRIEND (Print or Type)

19. SIGNATURE OF DECEASED PERSON'S NEIGHBOR (Print or Type)

1954
 1/24

General Administrator
 General Occurrence

X

BUREAU V. S.

DEC 28 1955

RECEIVED

Dr. Frank R.

July

Dec 14 1955
 Williamson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11926
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11922
No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Cambridge R.F.D. #2</u>		LENGTH OF STAY (in this place) <u>6 Yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Cambridge R.F.D. #2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home of Mrs. John Burton</u>				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Mary</u>		(Middle) <u>Dixon</u>		(Last) <u>Willey</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>12/13/1874</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>81</u> yrs.		4. DATE OF DEATH: (Month) <u>Dec.</u> (Day) <u>29</u> (Year) <u>1955</u>	
11. BIRTHPLACE (State or foreign country): <u>Lakesville, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Henry L. Dixon</u>				14. MOTHER'S MAIDEN NAME: <u>Amanda Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>X no</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. John Burton: Cambridge R.F.D. #2, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Uremia</u>							<u>1 wk.</u>
DUE TO							
Antecedent cause(s) (b) <u>Arteriosclerosis</u>							<u>?</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u>Fracture Neck L. Femur</u>							<u>10 days</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) <u>09</u> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 15 1955 10 M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Slipped and fell in home.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John M. [Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/30/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Pk.</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 30, 1955</u>		REGISTRAR'S SIGNATURE <u>John [Signature]</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Md.</u>	

RECEIVED

JAN 2 1966

BUREAU V. S.